Kitsap County Medicaid Waiver Project

Intensive Case Management for High Utilizers of Healthcare and Emergency Services

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	Which organizations were involved in developing this project suggestion? Kitsap Mental Health Services, Bremerton Housing Authority, Kitsap Public Health District, Kitsap Community Resources, City of Bremerton Fire Department, Central Kitsap Fire and Rescue, and the Kitsap County Department of Human Services.
Project Title	**Title of the project/intervention** Intensive Case Management for High Utilizers of Health and Emergency Services.

Rationale for the Project

Problem statement – Multiple healthcare transformation initiatives across the state and around the country have successfully demonstrated significant reductions in use of the Emergency Department (ED) and Emergency Medical Services (EMS) following the implementation of programs providing care coordination and supportive services for high utilizers of these services. These patients are often better served by intensive case management focused on stabilizing housing, accessing primary care, mental health, and/or chemical dependency treatment services, support with chronic disease management and supports enabling households to age in place. Kitsap County's ED and EMS services are similarly disproportionately accessed by a relatively small group of patients:

- Since 2013, 157 patients have been transported by the Central Kitsap EMS a total of 1,137 times, ranging from 5 trips to 28 trips. The Medicaid billing rate per transport is $ 230. (Bernt, 2016)
- The top 25 patients at Kitsap Mental Health Services have accessed Emergency Department services a total of 570 times in 2015. (Lewis, 2016).
- Pending: Data from Bremerton High Utilizers

Supporting research (evidence-based and promising practices) for the value of the proposed project.

- ***Tacoma Fire Department***: The Tacoma FD implemented a chronic care program in 2013, with 271 patients participating. From January 2013 – August 2015, 911 EMS & ED utilization declined (Bernt, 2016):
  2015: 911=96%; ED=99%
  2014: 911=87%; ED=86%
  2013: 911=85%; ED=87%
- ***Harborview Hospital in Seattle High Utilizer Program***: This program provides short-term intensive case management for high utilizers of the Emergency Department (4 visits in a 3 month period). The intervention reduced patient's use of the ED by 55% and inpatient charges by 63% (Allen, 2015).
- ***Snohomish County Fire District #1***: The Fire District implemented a community paramedic program in order to connect frequent 911 callers to required health and social services. In 2014, program participants experienced a 36% reduction in 911 calls and nearly a 12% reduction in ED visits. For the first six months of 2015, 911 calls were reduced by 50% and ED visits were reduced by 43.2% (MLTNews, 12/14/2015).
- ***San Diego Project 25:*** San Diego implemented a 3 year pilot program which identified 25 high users of ED, EMS, and in-patient hospitalization and connected them with long-term housing and supportive services. After one year, the per-person average expenditures were $97,437 down by $317,904. ED visits declined 77%, ambulance transfers declined 72% and in patient stays declined by 73%. (SDHC, June 7, 2012)

Relationship to federal Medicaid objectives with attention to how this project benefits Medicaid beneficiaries.
Consistent with the IHI Triple Aim Initiative, this project will: 1) Improve the patient experience of care (including quality and satisfaction) by offering appropriate care tailored to resolving the actual identified patient needs, 2) Improve the health outcomes of people served by this project by offering intense case management to ensure access to and compliance with appropriate health services, and; 3) Reduce the per-capita cost of health care of those served by reducing inappropriate reliance on ED and EMS services while supporting aging in place.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es).

- ✓ Reduce avoidable use of intensive services
- ✓ Improve population health, focused on prevention
- • Accelerate transition to value-based payment
- ✓ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es).

- ✓ Health Systems Capacity Building
- ✓ Care Delivery Redesign
- ✓ Population Health Improvement – prevention activities

Describe:

Region(s) and sub-population(s) impacted by the project. Include a description of the target population:

This project will serve Kitsap County residents who are identified as high users of ED and EMS services. The initial pool of the top 50 users will be selected based on a review and prioritization of Medicaid patients who are high users of these services as defined by being seen or transported to the ED five times within the past 12 months. After the initial patients are served, other individuals may be referred to the program from EMS, health care and social service providers, housing authorities and local law enforcement. Of the 50 people initially identified we expect that 25 will participate in the program, and the average length of intensive services will be six months.

Relationship to Washington's Medicaid Transformation goals.

This program is designed to improve patient care, improve health outcomes for participating patients and reduce the per-capita cost of health care incurred by these patients.

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.

1. Reduce utilization of ED and EMS services by individuals who are very low to no income and often experience health disparities exacerbated by serious mental illness, and/or chemical dependency, and homelessness.
2. Improve housing stability as evidenced by reduced evictions and placement in permanent housing programs.

Proposed interventions:

1. Create a Community Care Triage Team consisting of 2 Mobile Collaborative Care Managers, a Community Health Worker and a part-time program administrator. The Collaborative Care Managers will be a Master's Level Therapist or equivalent, BSN or MSN level with experience with co-occurring disorders and will make contact with the initial top 50 individuals and encourage participation. Program participants will receive intensive case management services including an in-depth health assessment and will be provided coordinated access to key services including Housing, Mental Health, Chemical Dependency Treatment services, Primary Care, minor home repair, and alternate transportation services. The Collaborative Care Manager will convene a provider team to coordinate patient services and strategies and the Community Health Worker will provide regular follow-up with daily requirements of the patient
2. Hire one EMS Community Paramedic to support outreach and education services across jurisdictions.

Links to complementary transformation initiatives

This program will complement several existing initiatives in the community including:

- o KC4TP (KC Cross Continuum Cares Transitions Project) – Redesigning the delivery of EMS services
- o Behavioral Health Crisis Triage and Sub-Acute Detox Center –Recovery oriented and sub-Acute detox services.
- o Kitsap Community Health Priorities Team –Improving housing stability, reducing ACES, and reducing obesity
- o Homeless Housing Plan Priorities including Housing First and housing case management program
- o Discharge planning including from jails, hospitals, and other institutions, and;
- o Regional Health improvement plan which takes into account chronic disease prevention, and aging in place.

Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.
Potential partners include: 1) EMS/ Integrated Mobile Services and local law enforcement, 2)Kitsap Mental Health Services, including the Crisis Triage and Sub-Acute Detox Center, 3) Kitsap Community Resources - provider of homeless housing and community support services, 4) Local health care organizations (i.e. Harrison Medical Center, the Kitsap County Public Health District, the local Federally Qualified Health Center, and Managed Care Organizations), 5) Local housing authorities (Bremerton Housing Authority and Housing Kitsap), 6) Olympic College, and; 7) Senior service providers (i.e. Long Term Care facilities and the Area Agency on Aging and Long-Term Care).

Core Investment Components

Proposed activities and cost estimates ("order of magnitude") for the project.
Develop assertive efforts to outreach and engage the identified patients in the ED, their homes, and/or in the community. Individuals will receive intensive services to provide linkage to housing, chemical dependency, mental health, aging in place and medical follow-up. This program will employ a harm reduction approach using motivational strategies and will include proactive outreach with the patient to social services agencies, case managers, health care providers, and community health professionals. Operating costs for this program are estimated to be $360,000 per year and will include hiring 2 Collaborative Care Managers ($140,000), 1 Community Health Worker ($45,000), 1 Part-Time Program Manager (50,000), and 1 EMS Community Paramedic ($125,000). The program requires basic program support ($10,000), transportation services ($5,000), and facility costs of ($10,000) and will be based at the Kitsap Public Health District.

Best Estimate for how many people you expect to serve, on a monthly or annual basis, when fully implemented:
We plan to serve 25 concurrent households for an average of 6 months, for a total of 50 individuals annually.

Best Estimate for how much you expect the program to cost per person served, on a monthly or annual basis:
The program is estimated to cost $7,200 per person served.

How long it will take to fully implement the project within a region where you expect it will have to be phased in? We will fully implement the program in 3 months.

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.
If each program participant reduced EMS and ED Medicaid costs by an average of $20,000 per person, then the program would reduce annual Medicaid expenditures for these patients by $1M and yield a payback on operating costs in 4.3 months. Assuming a 75% retention rate in the program in future years, this program would result in a sustained annual Medicaid Savings of $750,000 for this population. These savings would be replicated in future years as additional individuals are successfully served by this program.

Project Metrics:

Key process and outcome measures (and specific benchmark performance data if known)
- Reduce ED utilization, EMS Transports, and In-Patient Charges by 50% (benchmark data not currently available)

If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation?
We will track the actual utilization of ED and EMS services and related billings after 12 months in the program.

Sources Cited:

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